UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

IN RE: FOSAMAX (ALENDRONATE SODIUM) PRODUCTS LIABILITY LITIGATION (No. II)	MDL No. 2243 Civ. No. 08-08(JAP) (LHG)
This Document Relates To All Actions	

[PROPOSED] CASE MANAGEMENT ORDER NO. 5B
(Updating Certain Exhibit J Authorization Forms)

This matter having come before the Court on joint application of Plaintiffs, through Plaintiffs' Liaison counsel, and Merck Sharp & Dohme Corp. ("Merck"), by counsel, for entry of an order to amend Exhibit J to CMO 5 to update the authorization forms for Medco/Express Scripts, formerly Medco, and Express Scripts for the use and disclosure of health information, which forms must be completed by Plaintiffs as part of the Plaintiff Profile Form, and the Court having been advised that Medco/Express Scripts, formerly Medco, and Express Scripts have updated their authorization forms, and for good cause having been shown;

IT IS on this 7 day of Nov, 2013,

ORDERED that Exhibit J to CMO 5 be and hereby is amended in the form attached hereto to include the updated Medco/ Express Scripts and Express Scripts authorization forms.

JOEL A. PISANO
UNITED STATES DISTRICT JUDGE

AMENDED EXHIBIT J

CAREMARK
It all starts with care®

Authorization for a one-time written release of personal health information

Requesting the records of the following Plan Participant:
Last Name: _____
First Name: _____ Middle Initial: ____
Previous Last Name (if applicable): _____
Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____(mm/dd/yyyy) Phone Number: (____) _____-_____

Caremark Plan Participant's Primary Cardholder Identification Number(s):_____
Name of Requestor (if different than above): _____
Relationship to Plan Participant:
[ ] Self [ ] Legal guardian (Attach legal documentation)
[ ] Parent [ ] Other: _____ (Attach legal documentation)

I hereby authorize Caremark to release the following information for the above Plan Participant:
[ ] Statement of Cost (financial report) from _____(mm/dd/yyyy) to _____(mm/dd/yyyy)
[ ] Detailed Prescription History from _____ (mm/dd/yyyy) to _____(mm/dd/yyyy)
[ ] Other health information (please specify): _____
from_____(mm/dd/yyyy) to _____(mm/dd/yyyy)

This information should be released to: [ ] Check if same as address above.
Name: _____
Organization/Entity: _____
Address: _____
City/State/Zip: _____

The purpose of this authorization request is:
[ ] At request of plan participant
[ ] Required or requested by the recipient for purposes of _____
[ ] Other: _____

This Authorization will expire 90 days from the date of this authorization.

I understand that I have the right to revoke this Authorization at any time. This revocation will not affect any uses and/or disclosures already made based on this authorization before the revocation is received by Caremark. The revocation must be in writing and mailed to the address below. I understand that Caremark may not condition any treatment, payment, enrollment or my eligibility for benefits on my signing this Authorization. I understand that the information used and/or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by the federal privacy law.

I certify that the foregoing information is true and correct.

Signature: _____ Date: _____
Print Name: _____

If signed by someone other than the above-named plan participant, please describe your legal authority to act on behalf of the participant and, if applicable:_____ (Attach supporting documentation)

Witness Signature: _____
Witness Name: _____ Date: _____

Please Return Form To:
Caremark, Attn: Off Line Support
6950 Alamo Downs Pkwy, Ste 110
San Antonio, TX 78238
(Fax) 210 706-2401

PEM2046-0403

EXPRESS SCRIPTS®

Authorization to Use and Disclose Health Information

PLEASE PRINT CLEARLY

Patient's Name: _____ ID Number _____

Address: _____ SSN: _____
Street

_____ Date of Birth: ____/____/____
City, State, Zip MM DD YYYY

Plan Sponsor/Employer (if available) _____

[ ] Check here if Plan Sponsor is Department of Defense

I authorize Express Scripts, Inc. or one of its subsidiaries to use or disclose my health information as described below. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and no longer protected by federal privacy regulations.

1. The following health information may be used or disclosed:
   [ ] Prescription Claims Information/ Prescription History (PBM records)
   [ ] Check here if only mail order records are requested

2. The health information identified above may be used or disclosed for the following purpose(s):

   _____

   _____

3. The health information identified above may only be disclosed to the following individual(s) or organization(s):

   Name: _____

   Address: _____

   _____

4. I understand that the health information that I authorized to be used or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health and/or substance abuse.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment.

6. I understand that if this authorization is for the disclosure of health information for a research study, I may refuse to sign this authorization. I understand that if I refuse to sign this authorization, I may not receive the treatment related to the research study.

7. I understand that I may revoke this authorization at any time provided that the information has not already been disclosed. Information that has already been disclosed may not be further disclosed once the authorization has been revoked. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:

   Express Scripts, Inc.
   P.O. Box 66561
   St. Louis, MO 63166-6561

8. I understand that I have a right to request and receive a copy of Express Scripts' Notice of Privacy Practices at www.express-scripts.com.

9. A photocopy of this authorization is as valid as the original.

10. I understand that this authorization will expire one hundred eighty (180) days from the date signed below.

SIGNATURE

_____ _____
Signature of patient or patient's personal representative Date

_____
Printed name of patient or patient's personal representative

If signed by patient's personal representative, please complete the following:

Relationship to patient: _____

Authority to act for the patient:_____

Prescription Claims Information is readily available from 2002 to present. Patients wanting their own prescription claim information sent to their address on file should call the number on the back of their prescription identification card.

Please return completed form along with a check or money order for the non-refundable processing fee of $75.00 to:

Express Scripts, Inc.
Attn: Legal Department- Records
One Express Way
Mail Route HQ2E03
St. Louis MO 63121
866-254-2313 (fax)

Please allow 6-8 weeks for the request to be processed.
For questions or concerns, please call toll-free 800-332-5455, x344102.

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Rev. 08/09

L262-118741

RITE AID

Attorney Authorization

I authorize Rite Aid to disclose medical information at my request that it maintains to- _____ for use in my legal representation.

I understand that the potential exists for my information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and to be no longer protected.

This authorization will expire six months from the date of my signature as indicated below.

I understand that Rite Aid may not disclose my information as requested above without my signature on this Authorization and that my signing or refusing to sign this Authorization will not affect my ability to receive treatment, payment or health care operations from Rite Aid.

I understand that I have the right to revoke this authorization in writing at any time prior to the expiration date by sending my written revocation to Privacy Office, Rite Aid Corporation, P. O. Box 3165, Harrisburg, PA 17105. Any actions based on this Authorization that Rite Aid may have taken prior to their receiving notice of my revocation will be considered validly authorized.

Patient _____ Parent or Guardian _____
Power of Attorney _____ Court Appointed _____

Date_____ Signature _____
Printed Name_____
Social Security Number _____
Date of Birth _____

Walgreens

#106842

Return to: Walgreens Custodian of Records Department, 1901 East Voorhees Street, PO Box 4039, MS #735, Danville, Illinois 61834

All sections must be filled in completely or the authorization is NOT valid!!

AUTHORIZATION / RELEASE OF INFORMATION REQUESTED BY PATIENT

Your Name: _____

Date of Birth: _____

Street Address: _____

City, State, Zip _____

Telephone Number: _____

Person/organization authorized to receive information from Walgreens:

Name: _____

Address: _____

City, State, Zip: _____

Describe or list the information that you are asking us to release:

_____

_____

_____

_____

List the specific purpose for requesting this information:

_____

_____

_____

_____

Expiration Date (Must include a date or specific time frame):

This authorization expires *[specify date or event]*: _____

Information regarding this Authorization:

- You have the right to revoke this Authorization, in writing to Walgreens Custodian of Records Department, at any time. The revocation is only effective after it is received and logged by Walgreens. Any use or disclosure made prior to a revocation is not included as part of the revocation.
- Refer to our Notice of Privacy Practices for permitted uses and disclosures of protected health information ("PHI"). You may obtain a copy of this Notice from the Privacy Office or on www.walgreens.com. Please keep a copy of this authorization for your records.
- Once PHI is disclosed to others, it may be redisclosed by them to persons or entities that are not subject to the privacy regulations, which means that the PHI may no longer be protected by regulations.

- **Privacy regulations prohibit the conditioning of treatment, payment, enrollment, or eligibility for benefits on signing this Authorization.**
- **This Authorization must be signed and dated by the patient or signed and dated by the patient's personal representative and include a description of that person's ability to act on behalf of the patient.**

Signature

I, _____, by signing below, authorize Walgreens to use or disclose my protected health information as described above.

Signature **Date**

If this Authorization is signed by the patient's personal representative, please explain your authority to act and provide legal documentation.

L262-118808

WAL★MART NEIGHBORHOOD MARKET WAL★MART PHARMACY

Pharmacy Form
Authorization to Release Health Information

What is the Purpose of this Authorization?
This form is used by a Patient or Patient's personal representative to authorize Wal-Mart, SAM'S Club, and Neighborhood Market Pharmacies ("Pharmacy") to release health information to an individual or organization not otherwise authorized by law to receive it, as required by the Health Insurance Portability and Accountability Act ("HIPAA") and other state and federal privacy laws.

Section 1: Patient Information

Patient Name:			Date of Birth:
Address:			
City:	State:	Zip:	Phone:

Section 2: Information to be Released

(a) I authorize the release of the following health information:
- ☐ Specific Prescription(s): _____
- ☐ Medical Expense Summary (List of all prescription expenses)
- ☐ Designated Record Set (Entire medical record maintained by the Pharmacy)

(b) For the following dates of service:
- ☐ All dates of service — ALL (Include any archived records for same period.)
- ☐ From _____ to _____

(c) From the following Facilities: (list Wal-Mart, SAM'S, or Neighbor Market, including city and state)
- ☐ All locations where I have had prescriptions filled
- ☐ Only the following locations: _____

Section 3: Recipient and Purpose

Recipient Name:		Phone:
Name of Organization:		
Street Address:		
City, State, Zip:		
The purpose of this Authorization is:	☐ At the request of the Patient / Patient's personal representative ☐ Other (state reason): _____	

Section 4: Specific Consent

(a) I understand that my patient profile may include information related to treatment of mental health conditions, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases, or communicable diseases. I understand that the information, if any, pertaining to any of conditions described above may be released.

Please initial the statement that applies (you must initial one): I do _____ /I do not _____ authorize the release of this specific information.

If I authorize the release of this specific information, the recipient is prohibited from redisclosing this information without written authorization by me or my personal representative, unless permitted to do so under federal or state law.

Office Use Only: Please document in HIPAA notes field and file in HIPAA file.

Section 4: Specific Consent, Continued

Complete this section ONLY if you indicated that you do not authorize the release of specific health information related to treatment of mental health conditions, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases, or communicable diseases.

(b) Wal-Mart pharmacies do not record a diagnosis for most patient prescriptions. In order for Wal-Mart to exclude information related to these conditions, I must list specific drugs and/or prescription numbers that should not be released.

	Drug Name / Rx #	Date Range
1		
2		
3		
4		
5		
6		
7		
8		

	Drug Name / Rx #	Date Range
9		
10		
11		
12		
13		
14		
15		
16		

Section 5: Expiration Date of Authorization

This authorization will remain in effect under the following conditions: (check one)

- ☐ Until the following date: _____, 20
- ☐ Until the following event occurs: _____
- ☐ One Year from the date of my signature below.

Section 6: Signature

(a) I understand that signing this Authorization is voluntary. Receipt of Pharmacy services will not be conditioned upon my authorization of this disclosure.

(b) I understand that if I authorize the release of my health information to a recipient who is not legally required to keep it confidential, the information may be redisclosed and may no longer be protected by federal or state privacy laws.

(c) I have the right to revoke this Authorization in writing at any time by filling out a Revocation Form available at any Wal-Mart Pharmacy. The revocation will not apply to the extent that Wal-Mart has already released health information based on this Authorization.

_____ _____

Signature of Patient or Personal Representative — Today's Date

If you have signed this form as a legally authorized representative of the Patient, please print your name and relationship to the Patient below.

_____ _____

Name of Personal Representative (please print) — Relationship to Patient (parent, legal guardian, etc.)

☐ Please check (✓) this box if you would like to receive a copy of this form after you have signed it.

Office Use Only: Please document in HIPAA notes field and file in HIPAA file.

EXPRESS SCRIPTS medco

PLEASE PRINT CLEARLY

Authorization to Use and Disclose Health Information

Patient's Name: _____ ID Number: _____

Address: _____ SSN: _____
Street

_____ Date of Birth: ____/____/____
City, State, Zip MM DD YYYY

Plan Sponsor/Employer (if available) _____

I authorize Medco/ Express Scripts or one of its subsidiaries to use or disclose my health information as described below. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and no longer protected by federal privacy regulations.

1. The following health information may be used or disclosed:
[ ] Prescription Claims Information/ Prescription History (PBM records)
[ ] Check here if only mail order records are requested

2. The health information identified above may be used or disclosed for the following purpose(s):
_____

3. The health information identified above may only be disclosed to the following individual(s) or organization(s):

Name: _____
Address: _____
_____

4. I understand that the health information that I authorized to be used or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health and/or substance abuse.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment.

6. I understand that if this authorization is for the disclosure of health information for a research study, I may refuse to sign this authorization. I understand that if I refuse to sign this authorization, I may not receive the treatment related to the research study.

7. I understand that I may revoke this authorization at any time provided that the information has not already been disclosed. Information that has already been disclosed may not be further disclosed once the authorization has been revoked. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:

Medco / Express Scripts
P.O. Box 2660
Spokane, WA 99220-2660

8. A photocopy of this authorization is as valid as the original.

9. I understand that this authorization will expire one hundred eighty (180) days from the date signed below.

SIGNATURE

_____ _____
Signature of patient or patient's personal representative Date

_____
Printed name of patient or patient's personal representative

If signed by patient's personal representative, please complete the following:

Relationship to patient: _____

Authority to act for the patient: _____

Prescription Claims Information is readily available from 2005 to present.

Please return completed form along with a check or money order for the non-refundable processing fee of $75.00 to:

Medco / Express Scripts
Attn: - Records
P.O. Box 2660
Spokane, WA 99220-2660

Please allow 6-8 weeks for the request to be processed.
For questions or concerns, please call toll-free 800-626 6099 ext 7171.

TARGET Pharmacy Fax 215-699-7767

AUTHORIZATION FOR RELEASE OF RECORDS

I authorize Target Pharmacy at my request to release my prescription profile to the individual identified below. I understand I can revoke this authorization at any time prior to its expiration, which unless otherwise indicated will be six (6) months from my execution of this authorization. In order to revoke this authorization, I must submit a written revocation to my local Target Pharmacy, and I understand that the revocation will be valid from the date received by the pharmacy, except to the extent the pharmacy has already taken action in reliance on this authorization. I understand that Target Pharmacy cannot refuse to fill my prescriptions based on whether I sign this authorization. I understand the information disclosed could be subject to redisclosure by the person receiving records as identified below, and no longer protected by federal privacy regulations. I have retained a copy of this authorization for my records.

Print Patient Name: _____ Date of Birth: _____

Dates of Records Request:

Start Date: _____ End Date: _____

Name and Mailing Address of Individual to Receive Records

_____

_____

_____

Patient Signature: _____ Today's Date: _____

CERTIFICATION

If you are requesting records of another person who is unable to sign this authorization, complete the top part of this form with the information of the person whose records you are requesting. You must also certify your authority to act as follows:

I hereby certify that I am authorized to act for the individual whose records are to be released pursuant to this authorization. My authorization to act for this individual is derived from (check applicable statements):

- ☐ Health Care Power of Attorney
- ☐ Legal Guardian
- ☐ Personal Representative
- ☐ Other (describe): _____

Sign Your Name: _____ Today's Date: _____

Target reserves the right to exercise its discretion in releasing the records of any individual to you.

F6373.09 (2/03)